

JAN 10 1952

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

318

1003

State File No. **43175**  
**11195**

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>Mo</b> b. COUNTY <b>2119</b>			
b. CITY OR TOWN <b>St. Louis</b>		c. LENGTH OF STAY (In this place) _____		c. CITY OR TOWN <b>ST. LOUIS</b>		d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Homer S. Phillips</b>	
3. NAME OF DECEASED (Type or Print) <b>Walter</b>		a. (First) _____ b. (Middle) _____ c. (Last) <b>Miles</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>Dec 13, 1951</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Col</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Sep</b>		8. DATE OF BIRTH <b>Mar 4, 1893</b>	
9. AGE (In years last birthday) <b>58</b>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <b>Ark. 1</b>	
12. CITIZEN OF WHAT COUNTRY? _____		13a. FATHER'S NAME <b>Tom Miles</b>		13b. MOTHER'S MAIDEN NAME <b>Unknown</b>		14. NAME OF HUSBAND OR WIFE _____	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>#7</b>		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME <b>Ernestine Foster</b> ADDRESS <b>4315<sup>th</sup> E. Cole Brilliant</b>			
18. CAUSE OF DEATH							
Enter only one cause per line for (a), (b), and (c)							
MEDICAL CERTIFICATION							
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) _____							
INTERVAL BETWEEN ONSET AND DEATH _____							
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.							
II. OTHER SIGNIFICANT CONDITIONS							
Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION <b>Bilateral Hydrocephalus</b> <b>Cardiac Hypertrophy</b>				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <b>H. B. H.</b>			
22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <b>2:00 p.m.</b> , from the causes and on the date stated above.							
23a. SIGNATURE <b>Walter Miles</b>		23b. ADDRESS <b>1300 Clark</b>		23c. DATE SIGNED <b>12/18/51</b>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal Dec 19/51</b>		24b. DATE _____		24c. NAME OF CEMETERY (OR REMARKS) <b>Jefferson Barracks</b>		24d. LOCATION (City, town, or county) (State) <b>St. Louis MO</b>	
DATE REC'D BY LOCAL REG. <b>DEC 18 1951</b>		REGISTRAR'S SIGNATURE <b>Earl Smith</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>F. C. Green</b> ADDRESS <b>4714 Delmar</b>			

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, ~~\_\_\_\_\_~~ \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_  
Student Embalmer

Signed Eugene Miles

Licensed Embalmer No. 3623

P. O. Address 4214 Delman

**Note:** The above **MUST BE SIGNED BY THE LICENSED EMBALMER** in his **OWN HANDWRITING**. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.